

PRINTED: 06/09/2011  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  06/06/2011
NAME OF PROVIDER OR SUPPLIER  HILLVIEW HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1666 HILLVIEW DRIVE ELIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the survey conducted on June 6, 2011, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

Administrator

6-14-11

3UCW21

If continuation sheet 1 of 1